Prescription Pain Medication Policy, Insurance, Incentives Work Group
Minutes
April 3, 2008
3:00-4:30

Present:
Jeff Hawley
Carla Cook
Kathy Hoenig
Erin Johnson
Jerry Shields

Agenda:

1. Brainstorm: which current coverage practices may lead to negative outcomes with opioids?
2. Discussion: what do we need to do to make changes toward improvement?
3. Prioritize action steps
4. Delegate tasks

Discussion:
Department of Insurance uses policy forms--prior to selling an insurance policy in Utah, they need approval from state insurance department and need to comply with the law.

Each major medical policy/comprehensive policy offers a basic benefit package:
Covers hospital, physician, pharmacy, durable medical equipment

CMS (center for medicare and Medicaid services) can change and require changes for Medicare and Medicaid. (our regional office is in Denver)

The Department of Insurance regulates only commercial insurance agencies.
Insurance is broken down in the following percentages for Utah:
Commercial: 32% (percent of population in Utah covered by this group)
Includes: IHC, Altius, Regences, United Health, Molina, etc.
Employer Self Funded: 39%
Includes Deseret Mutual & Large School Districts, etc.
Government Sponsored: 18%
Includes Medicaid and Medicare
Uninsured: 11%
Other info: small groups can't safely self-fund (if 1 person gets diabetes, they whole group pays more). Small groups use commercial market to spread loss across more of the population. Trend in the 5-7 yrs is to shift toward self funded. Large commercial employers benefit from self funded (instead of having to comply with every states laws).

ERISA: The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans.

**Therefore changing state laws will only impact 32% of the insured in Utah.**

Changes: commercial requires state legislation, government require state & federal legislation. Leavitt could change a rule without changing a law (if there were no violations)

We can change prescribing practices.

Ideas of educating:

- Head of DHHS or Surgeon's General could send and publish a bulletin that would become permanent part of legal records.
- Can go to health Dept. legal council and see if a body of law applies to all 3 coverage areas (then we would only have to change a single law to impact the insured population instead of 3 separate laws to reach them).
- Each population has a different viewpoint: insurance's role is as a payer (not prescriber) so they are concerned with **cost (or changing what people pay for) and medical necessities (redefining what it is**).
- We need to give tools to physicians before we can change policies
- Need data to back up any ideas of policy change (or show formularies or coverage lists)
- Jerry--Put pharmacists in charge of deciding what drug to prescribe and let physicians do the diagnosing (would solve the problem of having thousands of samples in dr. offices)